

(Please fax completed forms to: 303-346-9309)

MEDICAL PATIENT INFORMATION: South Suburban Family Medicine

Patient Information:

Patient Name _____
Date of Birth _____ S.S.# _____ Sex M / F
Home Address _____
City, State, Zip _____
Phone: Home _____ Cellular _____ Work _____
Emergency Contact Name _____ Phone _____
Patient Employer _____
Patient E-mail _____

Policyholder/Primary Guarantor Information (If different from patient):

Policyholder/Guarantor Name _____
Date of Birth _____ S.S.# _____ Sex M / F
Home Address _____
City, State, Zip _____
Phone: Home _____ Cellular _____ Work _____
Employer _____

Primary Insurance

Insurance Company _____
Patient Member/ID Number _____
Group/Account Number _____
Office Visit Co-Payment \$ _____

Secondary Insurance

Insurance Company _____
Patient Member/ID Number _____
Group/Account Number _____

Understand your health insurance benefits: Health insurance benefits can be quite confusing, however it is your responsibility to know your benefits before making any appointments. Does your insurance cover physicals and preventive care? What services are not covered? Does your insurance require referrals? Please inform our office up front about your benefits to avoid any confusion in the future.

Financial agreement and assignment of benefits: I understand that I am financially responsible for my treatment and agree to pay this office for all charges including co-pays at each visit, deductibles, and any other services not covered by my insurance. I authorize payment directly to this office for all benefits paid on my behalf. I will assume all collection fees and court costs, if my account goes to collections.

Notice of privacy practices: South Suburban Family Medicine may release my protected health information only for the purposes of treatment, payment or health care operations.

I authorize this office to leave messages about my labs, x-rays and other tests if I cannot be reached.
Please checkmark where messages can be left: Home Cellular Work

I authorize the release of my labs, x-rays and other tests to the following persons _____

For more detailed information please refer to the *Notice Of Privacy Policies* brochure.

Treatment consent: I hereby voluntarily agree to diagnostic procedures, medical and surgical treatment for myself and/or dependents. By signing below I accept the terms of this agreement and acknowledge receiving the *Notice Of Privacy Policies* brochure.

Patient/Responsible Party _____ Date _____

MEDICAL HEALTH FORM (cont)

Name _____

Family History	Living Y / N	Name	Age	List Family Member Medical Problems
Mother				
Father				
Brother/Sister #1				
Brother/Sister #2				
Brother/Sister #3				
Brother/Sister #4				

Please check any items, which currently apply to you

	<input checked="" type="checkbox"/>
Weight gain	
Weight loss	
Unusual Fatigue	
Sleep Disorder	
Disabled	
Hepatitis	
Rheumatic Fever	
Tuberculosis	
Venereal Disease	
Asthma	
Eczema	
Hay Fever	
Hives	
Diabetes	
High Cholesterol	
Thyroid Problem	
Anemia	
Bruising	
Unusual Lumps	
Skin Problem	
Glaucoma	

	<input checked="" type="checkbox"/>
Hearing Problem	
Ringing in Ears	
Sinus Infections	
Cough	
Breathing Problem	
Pneumonia	
Abdominal Pain	
Ulcers	
Vomiting Blood	
Bloody Stools	
Heartburn	
Gallbladder	
Appetite Change	
Hernia	
Hemorrhoids	
Polyps	
Arthritis/Gout	
Bursitis	
Fractured Bones	
Back Problem	

	<input checked="" type="checkbox"/>
Headaches	
Seizures	
Tremors	
Fainting	
Speech Problem	
Paralysis	
Memory Loss	
Dizziness	
Heart Murmur	
Chest Pain	
Ankle Swelling	
High Blood Pressure	
Racing/pounding Heart	
Bowel Control Problem	
Leaking Urine	
Kidney/Bladder Infections	

	<input checked="" type="checkbox"/>
Females Only...	
Menstrual Trouble	
Vaginal Discharge	
Abnormal Bleeding	
Tubal Infections	
Infertility	
Breast lumps/pain	
Sex Concerns	
Age Periods Began	
Number of pregnancies	
Number of miscarriages	
Number of abortions	
Caesarean Sections	
Impotence	
Birth control	
Type:	
Males Only...	
Changes in Urination	
Prostate Problems	
Lumps on Testicles	
Impotence	